Pure Resolutions LLC

An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left shoulder arthroscopy, RCR, SAD, DCE, Extensive debridement

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female who sustained an injury on xx/xx/xx. The patient developed complaints of pain in the left shoulder. The patient was initially placed on anti-inflammatories and referred for physical therapy. The patient completed nine sessions of physical therapy through 01/15. Further therapy was pending authorization as the patient was leaving town. MRI of the left shoulder on 01/26/15 noted full small full thick full small full thickness tear of the supraspinatus tendon without retraction. There was mild to moderate acromioclavicular joint hypertrophy and degenerative changes in the glenoid involving the central aspect. Radiographs of the left shoulder found no evidence for fracture. The patient was evaluated on 02/12/15 for persistent complaints of left shoulder pain. Physical examination noted pain at the terminus of forward flexion and abduction at the left shoulder. No loss of range of motion was evident. There was some weakness on external rotation to the left but there was good subscapularis push off strength. Positive impingement signs were evident with tenderness over the acromioclavicular joint. There was functional range of motion of the right elbow left elbow and wrist. recommended surgical repair of the supraspinatus tendon with decompression and lateral clavicular excision. Surgical requests for the left shoulder were denied on 02/24/15 as the amount of physical therapy was note specified or evidence of weakness or loss of range of motion. There was no evidence for impingement or indication of symptomatic acromioclavicular arthritis. The request was again denied on 03/11/15 due to lack of clinical documentation of conservative treatment or evidence of impingement and severe degenerative disease of the acromioclavicular joint on MRI.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient was followed for complaints of left shoulder pain that persisted despite eight to nine sessions of physical therapy and anti-inflammatories. In total the treatment continued for more than three months however physical therapy has been somewhat limited due to authorization issues. There is no clinical documentation of diagnostic injections which would be indicated per guidelines for the proposed rotator cuff repair and subacromial decompression. The patient has a small full thickness rotator cuff tear at the supraspinatus tendon only. There is no evidence of significant weakness or loss of range of motion on physical examination to support urgent surgical intervention over continuing non-operative care. Patient has positive impingement signs noted however without clinical documentation of reasonable failure of conservative treatment and dying positive response to diagnostic injections neither the rotator cuff repair or subacromial decompression would be indicated per guidelines. The patient had some mild acromioclavicular joint arthritis on MRI however there was no extensive disease that would reasonably contribute to the overall conditions of the left shoulder. There was no evidence of loose bodies or other pathology requiring extensive debridement on MRI. As the clinical documentation submitted for review does not meet guideline recommendations for proposed procedures it is the opinion of this reviewer that medical necessity for the case is not medical necessity for the surgical request is not indicated is not established and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)